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# The right of everyone to the enjoyment of the highest attainable standard of physical and mental health

## Note by the Secretary-General*

The Secretary-General has the honour to transmit to the General Assembly the report of Paul Hunt, Special Rapporteur of the Commission on Human Rights, on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, submitted in accordance with Commission resolution 2004/27.

* The present report is submitted late so as to include as much up-to-date information as possible.

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*Summary*

The present report reflects on the activities of, and issues of particular interest to, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health ("the right to health"), since his last report to the Commission on Human Rights (E/CN.4/2004/49).

Section II points out that one of the most striking features of the Millennium Development Goals is the prominence they give to health. The Special Rapporteur shows how the right to health can contribute to the achievement of the Millennium Development Goals related to health, for example, by ensuring that vertical health interventions strengthen health systems and by reinforcing Goal 8 (a global partnership for development).

Section III briefly draws attention to the profound disparities in health for indigenous peoples in many countries and calls for urgent and concerted efforts, at local, national and international levels, towards reversing these trends.

In his preliminary report to the Commission on Human Rights (E/CN.4/2003/58), the Special Rapporteur observed that a State needed indicators and benchmarks if it was to monitor the progressive realization of the right to health. In his first interim report to the General Assembly (A/58/427), the Special Rapporteur outlined a methodology for the use of indicators in relation to the right to health. In section IV of the present report, he experimentally applies this methodology to one vital element of the right to health: child survival.

## Contents

| | | *Paragraphs* | *Page* |
|---|---|---|---|
| I. | Introduction | 1–4 | 3 |
| II. | Health-related Millennium Development Goals | 5–54 | 3 |
| III. | Right to health for indigenous peoples | 55–58 | 12 |
| IV. | Right to health, child survival and indicators | 59–84 | 14 |
| V. | Conclusions | 85–88 | 29 |
| Annex | | | |
| | Millennium Development Goals and human rights standards | | 31 |

# I. Introduction

1. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health ("right to health") submitted his preliminary report (E/CN.4/2003/58) to the Commission on Human Rights at its fifty-ninth session, in accordance with the mandate set out in Commission resolution 2002/31. In its resolution 2003/28, the Commission took note with interest of the report of the Special Rapporteur and invited him, inter alia, to submit annually an interim report to the General Assembly on the activities performed under his mandate. The first interim report of the Special Rapporteur is contained in document A/58/427.

2. At its fifty-eighth session, the General Assembly adopted, for the first time, a resolution on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (58/173). The Assembly took note with interest of the interim report of the Special Rapporteur and of, inter alia, the approach he proposed "to encompass the responsibilities of States at all levels in his future work on how to evaluate the progressive realization of the right of everyone to the highest attainable standard of physical and mental health, and of his efforts to apply this approach to specialized areas of health care, such as essential medicines, sexual and reproductive health, HIV/AIDS, children's health and water and sanitation".

3. The Special Rapporteur submitted his annual report to the Commission at its sixtieth session (E/CN.4/2004/49 and Add.1 and 2). In its resolution 2004/27, the Commission took note of the report and again requested the Special Rapporteur to submit annually a report to the Commission and an interim report to the General Assembly on the activities performed under his mandate. The present report is submitted in accordance with Commission resolution 2004/27.

4. Since he submitted his annual report to the Commission in February 2004, the Special Rapporteur has undertaken country missions to Peru (5-15 June) and Romania (23-27 August) at the invitation of those Governments.[1] Reports on these two missions, as well as on his mission to Mozambique in December 2003, will be submitted to the Commission at its sixty-first session. The Special Rapporteur also has issued a number of urgent appeals and other communications to various Governments, as well as press releases on issues ranging from the impact of trade agreements on access to medication to the enjoyment of the right to health in conflict situations, and will report on these communications in his forthcoming annual report to the Commission.

# II. Health-related Millennium Development Goals

5. The Millennium Development Goals represent one of the most important strategies in the United Nations. They provide a crucial opportunity for the human rights community to influence poverty reduction policies and practice at the national and international levels. The Goals have much to offer human rights, just as human rights have much to offer the Goals.

6. Although the Goals have generated a great deal of literature, human rights receive only slight attention in this rich material.[2] This is especially surprising given the close correspondence between the Goals and a number of human rights,

including the rights to health, education, food, shelter, and gender equality. As the Secretary-General stated in his report containing the road map for the implementation of the Millennium Development Goals, "economic, social and cultural rights are at the heart of all the millennium development goals" (A/56/326, para. 202).

7. In this chapter, the Special Rapporteur signals the contribution that the right to health can make to the realization of the health-related Goals.[3] A central theme is that human rights and the right to health reinforce many existing features of the Goals. Because of space constraints, the discussion is brief and illustrative.[4]

**Millennium Development Goals**

8. Representatives of 189 Member States, including 147 heads of State or Government, adopted the United Nations Millennium Declaration at the Millennium Summit in New York in September 2000. The Declaration sets out principles and values to govern international relations in the new century and it identifies seven areas in which national leaders make a series of specific commitments. The seven areas include development, poverty eradication and human rights.

9. The road map developed by the Secretary-General to implement the United Nations Millennium Declaration (A/56/326) identifies specific goals in relation to each of the seven areas. The goals in chapter III — on development and poverty eradication — are now referred to as the Millennium Development Goals. Chapter V — on human rights, democracy and good governance — contains six millennium human rights commitments. The eight Millennium Development Goals and six millennium human rights commitments are complementary and mutually reinforcing.

10. Since its adoption, the Declaration has been repeatedly affirmed, including in the Monterrey Consensus adopted at the International Conference on Financing for Development in 2002. Today, the entire United Nations "family" is giving urgent priority to the achievement of the Goals. So far as the Special Rapporteur is aware, no other set of international commitments and policy objectives has attracted such strategic, systemic and sustained attention since the foundation of the United Nations in 1945.

**Health-related Millennium Development Goals**

11. One of the most striking features of the Goals is the prominence they give to health. Of the eight Goals, four are directly related to health:

- Reduce child mortality (Goal 4);
- Improve maternal health (Goal 5);
- Combat HIV/AIDS, malaria and other diseases (Goal 6);
- Ensure environmental sustainability (including reducing by half the proportion of people without sustainable access to safe drinking water (Goal 7).

Two other goals are closely related to health: Goal 1 (to eradicate extreme poverty and hunger), and Goal 8 (to develop a global partnership for development).[5] Both remaining goals (achieving universal primary education and empowering women,

Goals 2 and 3) have a direct impact on health. It is well documented that educated girls and women provide better care and nutrition for themselves and their children.

12. Further, at least 8 of the 16 Millennium Development Goal "targets" and 17 of the 48 "indicators" are health-related.[6]

13. Health is central to the Millennium Development Goals because it is central to poverty reduction and development. Good health is not just an outcome of poverty reduction and development: it is a way of achieving them. But it is also more than that. International law — and numerous national constitutions — recognize the human right to the highest attainable standard of physical and mental health.

**Right to the highest attainable standard of health**

14. An extensive and nuanced body of international and national law elaborates the scope of the right to health. In his various reports, the Special Rapporteur has begun to set out and examine this law and practice. He will not repeat this exercise here. Instead, for ease of reference, he provides a brief introduction to the right to health.

15. Adopted in 1946, the Constitution of the World Health Organization (WHO) recognizes the fundamental human right to health. Two years later, the Universal Declaration of Human Rights laid the foundations for the international legal framework for the right to health. Since then, the right to health has been codified in numerous legally binding international and regional human rights treaties. The most extensive treaty elaboration of this right is in the Convention on the Rights of the Child, which has been ratified by all States, bar two. Further, these binding treaties are beginning to generate case law and other jurisprudence that shed light on the content of the right to health. The right to health is also enshrined in numerous national constitutions: over 100 constitutional provisions include the right to health, the right to health care, or health-related rights such as the right to a healthy environment. Moreover, in some jurisdictions constitutional provisions on the right to health have generated significant jurisprudence, such as the 1998 Argentinean court case of *Viceconti v. Ministry of Health and Social Welfare*.[7]

16. The right to health includes the right to health care, but it goes beyond health care to encompass safe drinking water, adequate sanitation and access to health-related information, including on sexual and reproductive health. The right includes freedoms, such as the right to be free from discrimination and forced sterilization. It also includes entitlements, such as the right to a system of health protection. The right has numerous elements, including child health, maternal health, and access to essential drugs. Like other human rights, it has a particular preoccupation with the disadvantaged, the vulnerable, and those living in poverty. The right requires an effective, inclusive health system of good quality.

17. Although subject to progressive realization, the right to health imposes some obligations of immediate effect, such as non-discrimination. It demands indicators and benchmarks to monitor the progressive realization of the right. The right to health also encompasses the active and informed participation of individuals and communities in health decision-making that affects them. Under international human rights law, developed States have some responsibilities towards the realization of the right to health in poor countries. Because the right to health gives

rise to entitlements and obligations, it demands effective mechanisms of accountability.

18. It is clear from this sketch that there is considerable overlap between the health-related Millennium Development Goals and the right to health. The Goals and some of their corresponding provisions in international human rights law are contained in the annex.

19. In conclusion, our understanding of the right to health is deepening. Of course, there are grey areas — and there are also good-faith disputes and disagreements, just as there are in all fields of inquiry. But the important point is that the right to health is not a slogan; it has normative depth and something constructive and concise to say about poverty reduction, development and the Millennium Development Goals.

**What does the right to health bring to the Millennium Development Goals?**

20. The following paragraphs provide a few examples of what the right to health brings to the health-related Millennium Development Goals. Some of the illustrations reflect what human rights, in general, contribute, for example, greater participation, while others reflect what the right to health specifically contributes, for example, more attention to health systems. For a number of reasons, not least shortage of space, the discussion does not focus in detail on specific Goals, although there are several paragraphs on Goal 8 (a global partnership for development).

*Helping to deliver the Millennium Development Goals to the disadvantaged and vulnerable*

21. The twin principles of non-discrimination and equality are among the most fundamental elements of international human rights, including the right to health. Both principles are enumerated and elaborated in numerous international instruments. The international community has established two human rights treaty bodies (one on women, the other on race) that focus exclusively on non-discrimination and equality.

22. The health-related Millennium Development Goals are framed in terms of societal averages, for instance, to reduce the maternal mortality ratio by three quarters (Goal 5). But the average condition of the whole population can be misleading: improvements in average health indicators can mask a decline for some disadvantaged groups. Because of this, human rights require that, so far as practical, all relevant data be disaggregated by the prohibited grounds of discrimination. In this way, it becomes possible to monitor the situation of vulnerable groups — women living in poverty, indigenous peoples, minorities and so on — and design policies that specifically address their disadvantage.[8]

23. This is one of the areas in which the right to health has a particular contribution to make to the achievement of the health-related Millennium Development Goals. Because of the special attention that it has devoted to these issues over many years, including the systematic consideration of hundreds of reports from States on their law and practice, the international human rights system has a wealth of experience on non-discrimination and equality that can help to identify policies that will deliver the health-related Goals to all individuals and groups, including those that are most disadvantaged.

*Enhancing participation*

24. Participation is an integral feature of the right to health. While the right to participate in the conduct of public affairs is inextricably linked to fundamental democratic principles, it means more than free and fair elections. It also extends to the active and informed participation of individuals and communities in decision-making that affects them, including decisions that relate to health. In other words, the right to health attaches as much importance to the processes by which health-related objectives are achieved as to the objectives themselves.

25. While strategies for development and poverty reduction must be country-driven, country ownership should not be understood narrowly to mean ownership on the part of the Government alone. The strategy has to be owned by a wide range of stakeholders, including those living in poverty. Of course, this is not easy to achieve and takes time. Innovative arrangements are needed to facilitate the participation of those who are usually left out of policy-making. Moreover, these arrangements must respect existing local and national democratic structures.

26. While the Millennium Development initiative is highly commendable, it exhibits some of the features of the old-style, top-down, non-participatory approach to development. A greater recognition of the right to health will reduce these technocratic tendencies, enhance the participation of disadvantaged individuals and communities, and thereby improve the chances of achieving the health-related Millennium Development Goals for all.

*Ensuring that vertical interventions strengthen health systems*

27. The right to health requires, inter alia, the development of effective, inclusive health systems of good quality. For the most part, the health-related Millennium Development Goals are disease specific or based on health status — malaria, tuberculosis, HIV/AIDS, maternal health and child health — and they will probably generate narrow vertical health interventions. Specific interventions of this type are not the most suitable building blocks for the long-term development of health systems. Indeed, by drawing off resources and overloading fragile capacity, vertical interventions may even jeopardize progress towards the long-term goal of an effective, inclusive health system. A proper consideration of the right to health, with its focus on effective health systems, can help to ensure that vertical health interventions are designed to contribute to the strengthening of good quality health systems available to all.

28. In this context, the Special Rapporteur notes with interest the idea of developing a new tool — a "health system impact assessment" — that would assess the anticipated impact of a suggested intervention on a particular health system, as recommended by the Millennium Project Task Force 4 on Child Health and Maternal Health in its interim report.

*More attention to health professionals*

29. Health professionals — doctors, nurses, midwives, technicians, administrators and so on — have an indispensable role to play in the realization of the health-related Millennium Development Goals. However, human resources are in crisis in many health systems. Unless the plight of health professionals is given the most serious attention, it is hard to imagine how the health-related Millennium

Development Goals will be achieved in many countries. The difficult situation of health professionals bears closely upon the right to health. For example, fair terms and conditions of employment for health professionals is a right to health issue. The "skills drain" of health professionals from South to North is also a right to health issue, as is the rural-to-urban migration of health professionals within a country. The South to North "skills drain" is relevant to Goal 8 because policies in countries of the North tend to drain the pool of health professionals away from developing countries. The right to health can help to ensure that these complex issues concerning health professionals, which impact directly upon the achievement of the health-related Millennium Development Goals, receive the careful attention they deserve.

*Sexual and reproductive health*

30. As is well known, the term "sexual and reproductive health" was excluded from the Millennium Development Goals. However, a developmental strategy that fails to include sexual and reproductive health issues would not be credible. Thus, in fact, the Millennium Development Goals do encompass sexual and reproductive health issues, such as maternal health, child health and HIV/AIDS. As confirmed by the Commission on Human Rights in resolution 2003/28, "sexual and reproductive health are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". In his report to the Commission at its sixtieth session, the Special Rapporteur explored the scope of the rights to sexual and reproductive health in the context of the Cairo and Beijing world conferences. He will not repeat that analysis here, but confirms that sexual and reproductive health includes women and men having the freedom to decide if and when to reproduce. This encompasses the right to be informed about, and to have access to, safe, effective, affordable, acceptable and comprehensive methods of family planning of their choice, as well as the right to go safely through pregnancy and childbirth.

31. In the context of the Millennium Development Goals, this element of the right to health has a crucial role to play by (i) affirming the vital importance of sexual and reproductive health in the contemporary struggle against global poverty; and (ii) highlighting the multiple human rights dimensions of sexual and reproductive health.

*Reinforcing Goal 8: a global partnership for development*

32. Developed States have some responsibilities towards the realization of the right to health in developing countries. These responsibilities arise, inter alia, from the provisions relating to international assistance and cooperation in international human rights law. Importantly, international assistance and cooperation should not be understood as meaning only financial and technical assistance: it also includes the responsibility of developed States to work actively towards an international order that is conducive to the elimination of poverty and the realization of the right to health in developing countries.

33. Like other human rights and responsibilities, the parameters of international assistance and cooperation are not yet clearly drawn. However, in principle, international assistance and cooperation require that all those in a position to assist should, first, refrain from acts that make it more difficult for the poor to realize their

right to health and, second, take measures to remove obstacles that impede the poor's realization of the right to health.

34. The human rights concept of international assistance and cooperation resonates strongly with Goal 8, the principles of global equity and shared responsibility that animate the United Nations Millennium Declaration, as well as the Monterrey Consensus. However, in addition, because it is enshrined in binding international human rights law, the human rights concept of international assistance and cooperation provides legal reinforcement to Goal 8, the Declaration's principles of global equity and shared responsibility, and the Monterrey Consensus.

35. In paragraphs 42 to 46 below, the Special Rapporteur returns to the vital issue of the accountability of developed States in relation to Goal 8.

*Strengthening accountability*

36. International human rights empower individuals and communities by granting them entitlements and placing legal obligations on others. Critically, rights and obligations demand accountability: unless supported by a system of accountability they can become no more than window-dressing. Accordingly, a human rights — or right to health — approach emphasizes obligations and requires that all duty-holders be held to account for their conduct.

37. All too often, "accountability" is used to mean blame and punishment.[9] But this narrow understanding of the term is much too limited. A right to health accountability mechanism establishes which health policies and institutions are working and which are not, and why, with the objective of improving the realization of the right to health for all. Such an accountability device has to be effective, transparent and accessible. It would appear to be this understanding of accountability that Task Force 4 on Child Health and Maternal Health has in mind when it advocates "constructive accountability".

38. Accountability comes in many forms. At the international level, human rights treaty bodies provide an embryonic form of accountability, while at the national level a health commissioner or ombudsman may provide a degree of accountability. A democratically elected local health council is another type of accountability mechanism. Administrative arrangements, such as publicly available health impact assessments, may also enhance accountability. In relation to a human right as complex as the right to health, a range of accountability mechanisms is required and the form and mix of devices will vary from one State to another.

39. The accountability mechanisms of the Millennium Development Goals are weak. One possible vehicle for accountability is the country-level Millennium Development Goals report. To date, over 60 such reports have been published, the great majority of which are about low-income or middle-income countries. In its assessment of the reports, the United Nations Development Programme (UNDP) observes that they "are emerging as one of the most important instruments for tracking and monitoring progress at the national level".[10] They are, however, primarily intended for "awareness advocacy", rather than policy formulation or accountability.[11]

40. Human rights, including the right to health, can strengthen the weak accountability mechanisms presently associated with all Millennium Development Goals in at least two ways. First, provided they are adequately briefed and

resourced, existing human rights accountability mechanisms can consider the adequacy of what States are doing to achieve the them. For example, the examination by a human rights treaty body of a State's periodic report could consider those goals falling within the treaty body's mandate. On country missions, special rapporteurs could explore those which fall within their mandates. At the country level, a national human rights institution could establish a Millennium Development Goal monitoring and accountability unit.

41. Second, human rights provide a constant reminder of the crucial importance of accountability in relation to the Millennium Development Goals. Human rights do not provide a neat standard-form accountability mechanism that can be applied to the Goals. The international community — and other actors — will have to identify appropriate, effective, transparent and accessible accountability mechanisms for integration into the Millennium Development initiative. If it does not, the Millennium Development Goals will lack an indispensable feature of human rights — and, more importantly, the chances of achieving them will be seriously diminished.

*Strengthening accountability for Goal 8*

42. While the accountability mechanisms in relation to all the Millennium Development Goals are weak, they are especially feeble in relation to Goal 8. The UNDP assessment report makes the point that "Significantly, few countries report on Goal 8" and stresses that it is of "the utmost importance to track progress on Goal 8".[12] A few developed States, including the Netherlands, Denmark and Sweden, have published reports on their progress towards Goal 8, very welcome precedents that all developed countries should follow as soon as possible. Although self-monitoring on Goal 8 by developed States is a step in the right direction, it does not constitute an adequate form of accountability.

43. There is a long-standing perception among developing countries that accountability arrangements are imbalanced and mainly applicable to them, while developed countries escape accountability when failing to fulfil their international pledges and commitments that are of particular importance to developing countries.[13] Unfortunately, the way the Millennium Development initiative is unfolding confirms this perception. The burden of reporting on the Millennium Development Goals falls mainly upon low-income and middle-income countries. Even self-monitoring on Goal 8 by developed countries is very thin. This imbalance is inconsistent with the principles of reciprocity, shared responsibility and mutual accountability upon which the United Nations Millennium Declaration and its Goals are based.

44. This imbalance is especially regrettable because of the crucial importance of Goal 8 to developing countries, many of which suffer from acute impoverishment on a national scale. For them it is not a matter of greater efficiency or fairer distribution among their citizens (although these considerations are often important); it is a question of an alarming shortage of resources and grossly inadequate budgets. In other words, to them, Goal 8 is absolutely vital.

45. From the point of view of human rights, including the right to health, it is imperative that the accountability arrangements in relation to Goal 8 be strengthened. If the international community is not able to agree on effective, transparent and accessible accountability mechanisms regarding Goal 8, developing

countries may wish to establish their own independent accountability mechanism regarding the discharge of commitments under Goal 8 by developed countries.

46. The Special Rapporteur confirms that he attaches particular importance to accountability in relation to Goal 8 because for many developing countries achieving the health-related Millennium Development Goals depends to a large degree upon developed States honouring their commitments under Goal 8.

**Conclusions**

47. Policies that are based on the right to health are more likely to be effective, equitable, robust, participatory and meaningful to those living in poverty.

48. The right to health brings an explicit normative framework that reinforces the health-related Millennium Development Goals. This framework is provided by international human rights. Underpinned by universally recognized moral values and backed up by legal obligations, international human rights provide a compelling normative framework for national and international policies designed to achieve the Goals.

49. In its resolution 2004/27, the Commission on Human Rights confirmed the importance of integrating the right to health into policy-making processes. Recalling the health-related Millennium Development Goals, the Commission recommended that States "take due account of the realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health in the formulation of their relevant national and international policies". The Commission did not confine itself to the responsibilities of States; it also urged "all international organizations" with mandates bearing upon the right to health "to take into account their members' national and international obligations related to [the right to health]".

50. The right to health — and other human rights — should be integrated into the four elements of the United Nations core strategy for the achievement of the Millennium Development Goals. No matter how able, the few members of the Millennium Project Task Forces who are conversant with human rights will not alone be able to ensure that human rights receive the attention they deserve. Neither will it be sufficient to obtain the comments of human rights experts on draft reports. If human rights and the right to health are to contribute fully to the achievement of the Millennium Development Goals, resources will have to be found for these issues to be consistently, coherently and systematically integrated throughout the Millennium Development Goal core strategy, not only at the international level but also in United Nations country teams.

51. It is especially important that the proposed "Global Plan to Achieve the Millennium Development Goals" expressly refers to and utilizes the human rights framework, in accordance with both the United Nations Millennium Declaration and the road map. It should include a chapter that identifies the human rights framework and emphasizes, with examples, how human rights complement and reinforce the Millennium Development Goals. Human rights and the right to health should then be coherently and consistently integrated across the Global Plan, including its recommendations.

52. The final report of each Millennium Project Task Force should include a chapter that identifies the human rights framework and explores its policy implications in relation to the subject matter for which the Task Force has particular responsibility.[14]

53. However, the integration of human rights in the Millennium Development Goals, including the right to health, presents those who are committed to human rights and poverty reduction with a significant challenge. The traditional techniques and skills that have served the human rights community so well for many years — "naming and shaming", letter-writing campaigns, taking test cases to court and so on — will not ensure the effective integration of the right to health into the Millennium Development strategy. If the right to health is to be integrated into the Millennium Development Goals, the human rights community will have to develop additional techniques and skills. For example, selecting priorities and making trade-offs are part of the inescapable reality of policy-making. Thus, if the human rights community is to engage with the Millennium Development Goals it will have to know how to select priorities in a way that is respectful of human rights. It will have to know how to identify which trade-offs are permissible and which are not from the point of view of human rights law and practice. It will also have to develop and use new tools, like impact assessments, indicators and benchmarks. Of course, the well-established human rights techniques remain vitally important: a Millennium Development Goal policy that violates human rights must be challenged in the traditional ways. However, while the traditional techniques are still essential, they are not enough, and additional skills are needed.

54. For its part, the human rights community is beginning to develop these additional techniques. Moreover, some of those who have traditionally worked on health and poverty reduction are increasingly aware that human rights have a significant contribution to make. In collaboration, both constituencies can help to ensure that human rights, including the right to health, contribute fully to the achievement of the health-related Millennium Development Goals for all.

## III. Right to health for indigenous peoples

55. The Special Rapporteur is deeply concerned about the profound disparities between the health of indigenous people and that of the non-indigenous population in many countries and communities around the world.[15] Indigenous people tend to die younger and generally live in poorer health than other population groups. In some jurisdictions, they are more likely to have chronic disorders such as diabetes, high blood pressure or arthritis, and are more prone to substance abuse, depression and other mental disorders than are non-indigenous people. Suicide rates among indigenous women in certain developed countries are as high as eight times the national average. HIV/AIDS and other sexually transmitted diseases are spreading rapidly in indigenous communities, a trend fuelled by factors including social and economic exploitation of indigenous women, as well as a lack of access to health-related information. Infant, child and maternal mortality rates in many indigenous communities are significantly higher than among non-indigenous groups, while indigenous children have lower vaccination rates, lower rates of school enrolment, higher dropout rates, and are more vulnerable than non-indigenous children to sexual and economic exploitation — all of which are risk factors to ill-health.

56. The purpose of this brief section is simply to highlight the importance of these complex issues, which the Special Rapporteur intends to explore in his forthcoming work. Already he has been provided with reliable information about disparities in the health of indigenous people, including examples of discrimination by health professionals, who lack training and awareness of the particular needs of indigenous people; a lack of health services available in indigenous languages; a lack of clean drinking water and adequate sanitation, and the impact of environmental contamination on the health and lives of indigenous communities; and violence, including sexual violence, against indigenous women. He notes the many similar concerns voiced by the Special Rapporteur on the situation of human rights and fundamental freedoms of indigenous people following his recent country missions. These include reports of systematic discrimination against indigenous peoples in access to medical services and in the quality of these services; the marginalization of traditional medicine of indigenous peoples; high rates of diseases such as diabetes; and alarming suicide rates, particularly among young indigenous men.[16]

57. In the report on its third session (E/2004/43-E/C.19/2004/23), the Permanent Forum on Indigenous Issues cautioned that health conditions in indigenous communities are deteriorating as a result of inadequate and limited access to health services, lack of culturally appropriate approaches to health care, lack of outreach clinics in remote areas, and deteriorating environmental conditions including air, water and land quality due to unchecked industrial development. It drew attention to the need to address factors which have a negative impact on the right to health of indigenous women, including sexual and reproductive rights. Positive measures are being taken in some countries to improve these conditions. However, a lack of health data specific to ethnicity, a recurrent failure to engage indigenous peoples in the development and implementation of health policies, and a scarcity of comprehensive research on health risks and disparities in relation to indigenous people has hampered progress on indigenous health initiatives.

58. The Special Rapporteur calls for urgent and concerted efforts, at local, national and international levels, towards reversing these trends. According to international human rights law, indigenous people have the right to specific measures to improve their access to health services and care as well as the underlying determinants of health. These services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. In particular, he urges Governments and other actors to make every effort to ensure:

(a) The disaggregation of health data by ethnicity, gender, socio-economic status, cultural or tribal affiliation and language;

(b) The active and informed participation of indigenous people in the formulation, implementation and monitoring of health policies and programmes;

(c) As far as possible, the availability of health facilities, programmes and projects, and health-related information, in languages spoken by indigenous peoples;

(d) The strengthening of health programmes in indigenous communities, including training of indigenous health workers to conduct outreach services to and home care in indigenous communities;

(e) Training of health professionals to ensure that they are aware of, and sensitive to, issues of ethnicity and indigenous culture;

(f) The development and implementation of strategies that encourage indigenous people to become health professionals. These strategies should include measures to increase the ethnic diversity of the student body attending existing training programmes, as well as the recognition of indigenous health practitioners, including traditional birth attendants, by State health care systems. Also, new training courses should be devised by — and for — indigenous and other non-dominant ethnic groups, including training in the medical traditions and practices of indigenous peoples;

(g) The establishment of monitoring and accountability mechanisms in indigenous communities in relation to abuses and neglect in the health system.

## IV. Right to health, child survival and indicators

59. In his preliminary report to the Commission on Human Rights, the Special Rapporteur observed:

> "The international right to health is subject to progressive realization. Inescapably, this means that what is expected of a State will vary over time. With a view to monitoring its progress, a State needs a device to measure this variable dimension of the right to health. [The Committee on Economic, Social and Cultural Rights] suggests that the most appropriate device is the combined application of national right to health indicators and benchmarks. Thus, a State selects appropriate right to health indicators that will help it monitor different dimensions of the right to health. Each indicator will require disaggregation .... Then the State sets appropriate national targets — or benchmarks — in relation to each disaggregated indicator. It may use these national indicators and benchmarks to monitor its progress over time, enabling it to recognize when policy adjustments are required. Of course, no matter how sophisticated they might be, right to health indicators and benchmarks will never give a complete picture of the enjoyment of the right to health in a specific jurisdiction. At best, they provide useful background indications regarding the right to health in a particular national context." (E/CN.4/2003/58, para. 36).

60. In the months following presentation of his preliminary report, the Special Rapporteur consulted widely with a view to identifying a straightforward methodology for right to health indicators and benchmarks. In his first interim report to the General Assembly (A/58/427), the Special Rapporteur set out such a methodology. In brief, the methodology:

(a) Addresses the difference between a health indicator and a right to health indicator;

(b) Proposes three categories of right to health indicators: structural, process and outcome;

(c) Proposes that right to health indicators are needed to monitor the discharge of a State's human rights responsibilities (a) within its own jurisdiction ("national level") and (b) beyond its borders ("international level").

61. The General Assembly noted the Special Rapporteur's approach with interest. Since the presentation of that report, the Special Rapporteur has discussed his approach with numerous human rights and other experts, including the participants of a workshop organized by WHO in April 2004. While some refinements have been suggested, on the whole the methodology has met with broad approval. Thus, the Special Rapporteur will now apply the methodology to a particular health specialization — child survival — with a view to exploring how it might work in practice.

**Children's right to health: child survival**

62. In its resolution 2002/31, the Commission on Human Rights requested the Special Rapporteur to pay special attention to the needs of children. Therefore, he wishes to apply the methodology set out in his interim report to one aspect of children's right to health.

63. For a number of reasons, not least the Millennium Development Goal on reducing child mortality, child survival is receiving increasing attention from States, intergovernmental organizations and civil society. In this context, an inter-agency consultative process is beginning to identify a draft set of core child survival indicators that all States, and other actors, might find helpful. The Special Rapporteur suggests that these indicators should be formulated in such a way that they are suitable for monitoring States' progressive realization of the right to health in relation to child survival.

64. Thus, the Special Rapporteur is taking the current draft set of core child survival indicators associated with the inter-agency process mentioned above, with a view to testing the methodology set out in his interim report. A number of preliminary points should be emphasized.

65. First, child survival is only one aspect of child health, so child survival indicators address only part of child health and children's right to health.

66. Second, the Special Rapporteur has a number of queries about the current draft core health indicators identified by the inter-agency process. For example, why are there no indicators on diarrhoea or HIV/AIDS? But in the present report the Special Rapporteur will neither amend nor add to the core health indicators being offered at present by the inter-agency process. If this might be useful, he is willing to engage with the inter-agency process and discuss its inclusion of some health indicators and not others. However, for the purpose of this report, the Special Rapporteur is retaining the core health indicators identified by the inter-agency process because they provide a useful vehicle for exploring how indicators can be used by a State to monitor its progressive realization of one component of the right to health: child survival.

67. Third, although the Special Rapporteur is neither amending nor adding to the core health indicators offered by the inter-agency process, he is drawing attention to some other indicators which are essential from the point of view of the right to health, for example, indicators on participation and accountability.

68. In the opinion of the Special Rapporteur, the core child survival indicators offered by the inter-agency process may properly be used to monitor some aspects of the progressive realization of the right to health provided:

(a) They correspond, with some precision, to a right to health norm;

(b) They are disaggregated by at least sex, race, ethnicity and rural/urban;[17]

(c) They are supplemented by additional indicators that monitor four essential features of the right to health:

(i) A national strategy and plan of action that includes the right to health;

(ii) The participation of individuals and groups, especially the vulnerable and disadvantaged, in relation to health policies and programmes;

(iii) International assistance and cooperation of donors in relation to the enjoyment of the right to health in developing countries;

(iv) Accessible and effective monitoring and accountability mechanisms.

69. In the table below, the child survival indicators associated with the inter-agency process are marked with an asterisk. The table also identifies right to health norms that correspond to these indicators. Further, the table includes a number of additional indicators that address issues which, from the point of view of the right to health, are essential, including national strategy and plan of action (indicators 8-10), participation (indicators 14 and 15), monitoring/accountability (indicators 1-12), and international assistance and cooperation (indicators 16-18 and 36-38).

70. In accordance with the methodology introduced in the interim report, the indicators are grouped as structural, process and outcome indicators. The table also sets out which indicators require disaggregation (structural indicators will usually not be susceptible to disaggregation). Finally, the table indicates the Government department likely to have responsibility collecting the relevant data, although this may vary among States.

71. While the table identifies indicators that a State may wish to use, of course a State may formulate additional child survival indicators that more closely reflect its particular context. The following indicators are simply offered as a common basket applicable to many States, although six of the indicators are specifically directed to donors.

72. In his interim report to the General Assembly, the Special Rapporteur noted that Eibe Riedel, Vice-Chair of the Committee on Economic, Social and Cultural Rights, has agreed to use the methodology set out in that report. The Special Rapporteur is pleased to note that the Vice-Chair also supports this chapter's application of the methodology to child survival thereby helping to ensure a consistent approach between the Special Rapporteur and Committee. Such consistency will simplify the work of States, intergovernmental organizations, civil society groups and others.

| *STRUCTURAL INDICATORS* | | | |
|---|---|---|---|
| **INDICATOR** | **DISAGGREGATION** | **SECTORAL RESPONSIBILITY** | **HUMAN RIGHTS PROVISION(S)**** |
| **Basic legal context**<br>1. Has the State constitutionalized the right to health, including children's right to health? *(yes/no)* | No | Ministry of Justice (MoJ) | ICESCR articles 2(1), 12; CRC articles 4, 6(2), 24 |
| 2. Has the State passed other legislation that expressly recognizes the right to health, including children's right to health? *(yes/no)* | | | |
| 3. In the last two years, have there been any reported judicial decisions that expressly consider children's right to health? *(yes/no)* | No | MoJ | ICESCR articles 2(1), 12; CRC articles 4, 6(2), 24 |
| 4. Has the State passed legislation on mandatory birth registration? *(yes/no)* | No | MoJ | ICESCR articles 2(1), 12; ICCPR article 24(2); CRC articles 4, 6(2), 7, 24 |
| 5. Has the State adopted the International Code of Marketing Breast-milk substitutes? *(yes/no)* | No | MoJ | ICESCR articles 2(1), 12; CRC articles 4, 6(2), 24(2)(a), (c) and (e); CEDAW article 12(2) |

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|---|---|---|---|
| **National human rights institution**<br>6. Does the State have a national human rights institution (eg a human rights commissioner, child commissioner or a health commissioner) the mandate of which:<br>(i) expressly includes children's right to health? *(yes/no)*<br>(ii) implicitly includes children's right to health? *(yes/no)* | No | MoJ | ICESCR articles 2(1), 12; CRC articles 4, 6(2), 24 |
| 7. If so, in the last five years has that institution run a programme, with designated staff and an allocated budget, on children's right to health? *(yes/no)* | | | |
| **National strategy and plan of action**<br>8. Within the last five years, has the Government adopted or updated a national strategy and plan of action on children's health, including child mortality? *(yes/no)* | No | Ministry of Health (MoH) | ICESCR articles 2(1), 12; CRC articles 4, 6(2), 24 |

| | | | |
|---|---|---|---|
| 9. If so, does the strategy/plan:<br>(a) expressly recognize the Convention on the Rights of the Child? *(yes/no)*<br>(b) systematically take into account and integrate the provisions of the Convention on the Rights of the Child? *(yes/no)*<br>(c) clearly identify:<br>(i) objectives? *(yes/no)*<br>(ii) timeframes? *(yes/no)*<br>(iii) the responsibilities of different sectors? *(yes/no)*<br>(iv) reporting procedures in relation to those objectives, timeframes and responsibilities? *(yes/no)*<br>(v) the best interests of the child as a guiding principle? *(yes/no)*<br>(d) include measures that are specifically designed to reach and benefit vulnerable groups? *(yes/no)* | No | MoH | ICESCR articles 2, 12; CRC articles 2, 3(1), 4, 6(2), 24 |
| 10. If there is a strategy/plan, are appropriate and sufficient data being collected to evaluate performance, particularly in relation to vulnerable groups? *(yes/no)* | No | MoH | ICESCR articles 2, 12; CRC articles 2, 4, 6(2), 24 |
| **Impact assessments**<br>11. Before introducing a new initiative that is likely to impact upon children's health, does the State have a policy of conducting a publicly available assessment of the likely impact of the initiative on children's health, including vulnerable groups? *(yes/no)* | No | MoH | ICESCR articles 2, 12; CRC articles 2, 4, 6(2), 24 |

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|---|---|---|---|
| **Monitoring and accountability**<br>12. Apart from those mentioned in 1-11 above, are there any effective and accessible mechanisms of monitoring and accountability by which local communities may hold local and national public officials to account in relation to the delivery of child health policies and programmes that affect them?<br>(a) local free and fair elections eg for community health boards? *(yes/no)*<br>(b) an international human rights treaty body eg the Committee on the Rights of the Child? *(yes/no)*<br>(c) other? | No | MoH | ICESCR article 12; CRC articles 4, 6(2), 24; ICCPR article 25; CEDAW articles 7, 14(2); CERD article 5(a), (c) and (e)(iv) |
| **Coordination**<br>13. Is there a Government-led inter-departmental mechanism for the review of child health issues on a regular basis (at least twice a year)? *(yes/no)* | No | MoH | ICESCR articles 2(1), 12; CRC articles 4, 6(2), 24 |
| **Participation**<br>14. Does the Government regularly consult with the following in the process of formulating, implementing and monitoring its child health policies:<br>(a) a wide range of different types of non-governmental organizations? *(yes/no)*<br>(b) representatives of a wide range of health professional organizations? *(yes/no)*<br>(c) local governments? *(yes/no)*<br>(d) representatives of a wide range of vulnerable groups, including those living in poverty? *(yes/no)* | No | MoH | ICESCR article 12; CRC articles 12 and 24; ICCPR article 25; CEDAW articles 7, 14(2)(a); CERD article 5(c) and (e)(iv) |

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|---|---|---|---|
| 15. Does the Government regularly disseminate information about its child health policies:<br>(a) to a wide range of non-governmental organizations? *(yes/no)*<br>(b) to a wide range of health professional organizations? *(yes/no)*<br>(c) to local governments? *(yes/no)*<br>(d) through media sources accessible in rural areas? *(yes/no)* | No | MoH | ICESCR, articles 2(1), 12; CRC articles 4, 6(2), 13, 17, 24; CEDAW articles 10(h), 14(2)(b); CERD article 5(e)(iv) |
| **International assistance and cooperation (these indicators are for donors):**<br>16. Do the State's reports to the Committee on the Rights of the Child and to the Committee on Economic, Social and Cultural Rights include an extensive and detailed account of the international assistance and cooperation it is providing?<br>*(yes/no/not applicable due to non-ratification of relevant treaty)* | No | Ministry of Foreign Affairs (MFA) | ICESCR articles 2(1), 11(1), 12, 15(4), 22, 23; CRC articles 4, 6(2), 24(4) |

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|---|---|---|---|
| 17. When a State is providing international assistance and cooperation to a recipient country, does it prepare a country-specific annual written report on this international assistance and cooperation and:<br>(a) submit this report to the Government of the recipient country? *(yes/no)*<br>(b) make the contents of the report available to the public in the recipient country? *(yes/no)* | No | MFA | ICESCR articles 2(1), 11(1), 12, 15(4), 22, 23; CRC articles 4, 6(2), 24(4) |
| 18. Is the Government's ODA policy rights-based? *(yes/no)* | | | |

***PROCESS INDICATORS***

| INDICATOR | DISAGGREGATION | SECTORAL RESPONSIBILITY | HUMAN RIGHTS PROVISION(S)** |
|---|---|---|---|
| **Infant feeding*** | Yes | MoH | ICESCR article 12(2)(a) and (c); CRC articles 6(2), 24(2)(a), (c), (d) and (e); CEDAW articles 11(2), 12 |
| 19. Proportion of infants less than 12 months of age who were put to the breast within one hour of delivery | | | |
| 20. Proportion of infants less than 4 months and less than 6 months who are exclusively breastfed | | | |
| 21. Proportion of children 12-15 months and 20-23 months who are breastfed | | | |

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|---|---|---|---|
| 22. Proportion of infants 6-9 months who are receiving breast milk and complementary food | | | |
| **Vitamin A*** 23. Proportion of children under five who have received a high dose of vitamin A supplement in the last six months | Yes | MoH | ICESCR article 12(2)(a); CRC articles 6(2), 24(2)(c) and (e) |
| **Malaria*** 24. Proportion of households with at least one insecticide-treated net during the previous night | Yes | MoH | ICESCR article12(2)(a) and (c); CRC articles 6(2), 24(2)(a), (c) and (e) |
| 25. Proportion of children under five who slept under an insecticide treated net during the previous night | Yes | MoH | ICESCR article12(2)(a) and (c); CRC articles 6(2), 24(2)(a), (c) and (e) |
| 26. Proportion of children under five with fever in the last two weeks who received appropriate anti-malarial treatment within 24 hours of the onset of fever | Yes | MoH | ICESCR article12(2)(a) and (c); CRC articles 6(2), 24(2)(a), (b) and (c) |
| **Water, sanitation and hygiene*** 27. Proportion of population who use any of the following types of water supply for drinking: (a) piped water to household (b) public standpipe/tap (c) borehole/pump (d) protected well (e) protected spring (f) rainwater | Yes | Ministry responsible for water and sanitation | ICESCR article12(2)(a) and (c); CRC articles 6(2), 24(2)(a) and (c) |

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|---|---|---|---|
| 28. Proportion of population who use any of the following types of sanitation facilities:<br>(a) toilet connected to sewage system<br>(b) toilet connected to septic system<br>(c) pour-flush latrine<br>(d) improved pit latrine<br>(e) traditional pit latrine | Yes | Ministry responsible for water and sanitation | ICESCR article12(2)(a) and (c); CRC articles 6(2), 24(2)(a) and (c) |
| **Immunization*** <br>29. Proportion of one-year-old children protected against neonatal tetanus through immunization of the mother | Yes | MoH | ICESCR articles 12(2)(a) and (c); CRC articles 6(2), 24(2)(a), (b), (c) and (f) |
| 30. Proportion of one-year-old children immunized against measles | | | |
| 31. Coverage of third dose of diptheria, tetanus and pertusis vaccine | | | |
| **Acute respiratory infection*** <br>32. Proportion of children under five with suspected pneumonia who received appropriate antibiotics | Yes | MoH | ICESCR article 12(2)(a), (c) and (d); CRC articles 6(2), 24(2)(a), (b) and (c) |
| 33. Proportion of children under five who had suspected pneumonia in the last two weeks and were taken to an appropriate health provider | | | |
| 34. Proportion of population using solid fuels | Yes | MoH | ICESCR article 12(2)(a), (b) and (c); CRC articles 6(2), 24(2)(a) and (c) |
| **Maternal health*** <br>35. Proportion of births attended by skilled health personnel (doctor, nurse or midwife) | Yes | MoH | ICESCR article 12(2)(a) and (d); CRC article 24(2)(a),(b) and (d); CEDAW article 12(2) |

| | | | |
|---|---|---|---|
| **International assistance and cooperation (these indicators are for donors):**<br>36. Percentage of ODA devoted to child health<br>37. Percentage of ODA spent on vaccine-preventable diseases in developing countries eg supplying or funding vaccines<br>38. Percentage of ODA spent on research and development to combat those diseases that especially afflict children in developing countries | No | MFA | ICESCR articles 2(1), 11(1), 12, 15(4), 22, 23; CRC articles 4, 6(2), 24(4) |
| ***OUTCOME INDICATORS*** | | | |
| **INDICATOR** | **DISAGGREGATION** | **SECTORAL RESPONSIBILITY** | **HUMAN RIGHTS PROVISION(S)**** |
| **Undernutrition***<br>39. Proportion of low-birth-weight live births (below 2500 grams) | Yes | MoH | ICESCR articles 11 and 12(2)(a); CRC articles 6(2), 24(2)(c) and (e), 27(3) |
| 40. Proportion of under-five-year-olds below -2 and -3 standard deviations from median weight-forage of NCHS/WHO reference population | | | |
| **Mortality***<br>41. Under-five mortality rate (probability of dying between birth and five years per 1000 live births) | Yes | MoH | ICESCR 12(2)(a); CRC articles 6 and 24(2)(a) |

| | | | |
|---|---|---|---|
| 42. Infant mortality rate (probability of dying between birth and one year per 1000 live births) | | | ICESCR 12(2)(a); CRC articles 6 and 24(2)(a) |

KEY

* Indicators marked with a single asterisk are taken from an ongoing inter-agency consultative process that is drafting a set of core child survival indicators. Although he has queries about them, the Special Rapporteur has not revised the draft core indicators emerging from this consultative process. Instead, for the purposes of this report he is using them as a vehicle to explore how indicators might be used by a State to monitor the progressive realization of the part of the right to health relating to child survival.

** ICESCR - International Covenant on Economic, Social and Cultural Rights
ICCPR - International Covenant on Civil and Political Rights
CERD - International Convention on the Elimination of All Forms of Racial Discrimination
CEDAW - International Convention on the Elimination of All Forms of Discrimination Against Women
CRC - Convention on the Rights of the Child

**An illustration: how child survival indicators and benchmarks can help a State monitor its progressive realization of the right to health**

73. The indicators in the table should be regarded as tools that States and others can use to help them monitor the progressive realization of the right to health in relation to child survival.

74. As explained in the Special Rapporteur's interim report, process and outcome indicators are especially useful when used with benchmarks. For example, a State may take a process indicator such as the proportion of births attended by skilled health personnel (indicator 35). National data may show that the proportion of births attended by skilled health personnel is 60 per cent. When disaggregated on the basis of urban/rural, data may reveal that the proportion is 70 per cent in urban centres but only 50 per cent in rural areas. When further disaggregated on the basis of ethnicity, data may also show that coverage in the rural areas is uneven: the dominant ethnic group enjoys a coverage of 70 per cent but the minority ethnic group only 40 per cent. This example shows the crucial importance of disaggregation. When disaggregated, the indicator confirms that rural women members of the ethnic minority are especially disadvantaged and require particular attention in relation to the right to maternal health.

75. Consistent with the progressive realization of the right to health, the State may decide to aim for a uniform national coverage of 70per cent — in the urban and rural areas and for all ethnic groups — in five years' time. Thus, the process indicator is the proportion of births attended by skilled health personnel — and the benchmark or target is 70 per cent. The State will formulate and implement policies and programmes that are designed to reach the benchmark of 70 per cent in five years. The right to health requires that these policies and programmes be participatory. The data show that the policies and programmes will have to be specially designed to reach the minority ethnic group living in the rural areas.

76. Annual progress towards the benchmark or target should be monitored, in the light of which annual policy adjustments might be required. At the end of the five-year period, a monitoring and accountability mechanism will be needed to ascertain whether or not the 70 per cent benchmark has been reached. If it has, the State will set a more ambitious benchmark for the next five-year period, consistent with it obligation to realize progressively the right to health. But if the 70 per cent benchmark has not been reached then the reasons should be identified, responsibility apportioned and remedial action taken.

77. Importantly, a failure to reach the benchmark does not necessarily mean that the State is in breach of its international right to health obligations. The State might have fallen short of the benchmark for reasons beyond its control. However, if the monitoring and accountability mechanism reveals that the 70 per cent benchmark was not reached because of — for example — corruption in the health sector, then it will probably follow that the State has failed to comply with its international right to health obligations.

78. International assistance and cooperation is an important element of the right to health. Donors have a responsibility to provide financial and other support for developing countries' policies and programmes regarding child survival. Moreover, donors should be held to account in relation to the discharge of their responsibility. So, in relation to the example set out in the preceding paragraphs, there should be a

monitoring and accountability mechanism that addresses the following question: has the donor community done all it reasonably could to help the State deliver sound child survival policies and programmes and reach its benchmark of 70 per cent?

79. In summary, disaggregated process indicators, such as the proportion of births attended by skilled health personnel, when used with disaggregated benchmarks, can help a State monitor whether or not it is progressively realizing the right to health. As explained in the Special Rapporteur's interim report, and exemplified in the table in the present report, structural indicators and outcome indicators — like process indicators — also have a crucial role to play. Taken together, structural, process and outcome indicators can help a State identify, in relation to the right to health, what needs to be done, which policies are working, and when programmes need adjusting.

**Conclusions**

80. This chapter is designed to advance the debate about the right to health, progressive realization and indicators. It takes the indicators methodology set out in the Special Rapporteur's interim report and applies it to child survival, drawing upon the set of draft core child survival indicators arising from an ongoing inter-agency consultative process. In short, there is an experimental dimension to the chapter, and comments are invited on it.

81. The Special Rapporteur suggests one important lesson that emerges from the chapter. Rather than searching for individual right to health indicators, it is probably more helpful to think in terms of a right to health or human rights approach to indicators. As outlined in paragraph 68 above, this approach has a number of elements. In summary, the indicators must be disaggregated. They must address a national strategy and action plan, participation, monitoring and accountability, and international assistance and cooperation. Also, the substantive health indicators themselves must correspond, with some precision, to a right to health norm.

82. It is not possible for one indicator to possess all these features. But, as this chapter has sought to show, it is possible to adopt this approach, apply it to a health specialization, like child survival, and identify *a range* of structural, process and outcome indicators that *together* have all these features. In combination, these various indicators can help a State monitor the progressive realization of the child survival component of the right to health.

83. The indicators in the table above are work in progress. For instance, the indicators on participation, accountability, and international assistance and cooperation need more work, and the Special Rapporteur will especially welcome suggestions on how they can be improved. Also, do the health indicators marked by an asterisk deriving from the ongoing inter-agency process correspond, with sufficient precision, to right to health norms? These and other issues need further discussion.

84. Nonetheless, the practical application of the methodology to child survival in the table above contributes to our understanding of the right to health, progressive realization and indicators. It begins to show, with specific examples, the main features of a right to health or human rights approach to indicators. The Special Rapporteur invites comments on this chapter so that he can continue to work on

health and indicators in a practical and principled manner that attracts as much support as possible.

## V. Conclusions

85. **This report tackles a number of the issues highlighted by the Special Rapporteur in his preliminary report to the Commission on Human Rights.**

86. **In his preliminary report, the Special Rapporteur had identified the two interrelated themes that animate much of his work: poverty and the right to health; and discrimination, stigma and the right to health. Both of these themes recur throughout the current report, for instance, section II on the health-related Millennium Development Goals and section III on indigenous peoples.**

87. **In his preliminary report, the Special Rapporteur also had observed that States need indicators and benchmarks if they are to monitor the progressive realization of the right to health. In his interim report to the General Assembly, the Special Rapporteur had outlined a methodology for the use of indicators in relation to the right to health. In section IV of the present report, he experimentally applies this methodology to one vital element of the right to health, child survival.**

88. **In short, the Special Rapporteur is pursuing the themes and issues that he identified in his preliminary report. He hopes to continue this process in his forthcoming work.**

*Notes*

[1] In addition, the Special Rapporteur has participated in several meetings including various consultations organized by the World Health Organization; the annual meeting of special rapporteurs organized by the Office of the United Nations High Commissioner for Human Rights; the Social Forum of the Subcommission on the Promotion and Protection of Human Rights; and a conference, Monitoring the Right to Health: special focus on HIV/AIDS, organized by the International Federation of Health and Human Rights Organizations.

[2] There are some notable exceptions. See, for example, the interim report of Task Force 4 on Child Health and Maternal Health of 19 April 2004; the comments of the Ethical Globalization Initiative on the interim report on combating HIV/AIDS of Task Force 5; the report of the Conference on Human Rights Perspectives on the Millennium Development Goals, organized by the New York University Center for Human Rights and Global Justice, on 11 November 2003; and the report entitled "80 million lives: Meeting the Millennium Development Goals in child and maternal survival" of the Grow Up Free from Poverty Coalition (2003).

[3] Its focus is the contribution of the right to health to the Millennium Development Goals, rather than how these can contribute to the right to health.

[4] So far as his resources have permitted, the Special Rapporteur has considered the health-related goals elsewhere, for instance in his first report to the Commission on Human Rights. Whenever possible in his country missions, he has considered and promoted them and used the national Millennium Development Goals Reports.

[5] For example, one of the targets contained in Goal 8 is to provide affordable essential drugs in developing countries.

[6] While there is some discussion about how many goals, targets and indicators are health-related, the prominence of health is undisputed.

[7] Poder Judicial de la Nación, Causa no. 31.777/96, 2 June 1998.

[8] Country-level situational analyses may identify vulnerable groups that are not expressly included in the grounds of discrimination prohibited under international human rights law but which nonetheless demand particular attention.

[9] See L. P. Freedman, "Human Rights, constructive accountability and maternal mortality in the Dominican Republic: a commentary", *International Journal of Gynaecology and Obstetrics*, vol. 82 (2003) pp. 111-114.

[10] DP/2003/34, para. 3.

[11] Ibid., para. 16.

[12] Ibid., paras. 9 and 31.

[13] UNDP, Bureau for Development Policy, "Is MDG 8 on track as a global deal for human development?", prepared by J. Vandenmoortele, K. Malhotra and J. A. Lim (New York, 2003).

[14] See the comments on the interim report on HIV/AIDS of Task Force 5 by the Ethical Globalization Initiative.

[15] See the report on the International Decade of the World's Indigenous People to the Fifty-fourth World Health Assembly (WHO document A54/33).

[16] The reports of the Special Rapporteur on indigenous people on his country missions are available at http://www.ohchr.org/english/issues/indigenous/rapporteur/visits.htm.

[17] The aim should be to disaggregate on as many of the internationally prohibited grounds as possible (see A/58/427, paras. 12 and 13 and endnote 6).

# Annex

## Millennium Development Goals and human rights standards[a]

| *Millennium Development Goal* | *Key Related Human Rights Standards* |
|---|---|
| Goal 1: Eradicate extreme poverty and hunger | Universal Declaration of Human Rights, article 25(1); ICESCR article 11 |
| Goal 2: Achieve universal primary education | Universal Declaration of Human Rights article 25(1); ICESCR articles 13 and 14; CRC article 28(1)(a); CEDAW article 10; CERD article 5(e)(v) |
| Goal 3: Promote gender equality and empower women | Universal Declaration of Human Rights article 2; CEDAW; ICESCR article 3; CRC article 2 |
| Goal 4: Reduce child mortality | Universal Declaration of Human Rights article 25; CRC articles 6, 24(2)(a); ICESCR article 12(2)(a) |
| Goal 5: Improve maternal health | Universal Declaration of Human Rights article 25; CEDAW articles 10(h), 11(f), 12, 14(b); ICESCR article 12; CRC article 24(2)(d); CERD article 5(e)(iv) |
| Goal 6: Combat HIV/AIDS, malaria and other diseases | Universal Declaration of Human Rights article 25; ICESCR article 12, CRC article 24; CEDAW article 12; CERD article 5(e)(iv) |
| Goal 7: Ensure environmental sustainability | Universal Declaration of Human Rights article 25(1); ICESCR articles 11(1) and 12; CEDAW article 14(2)(h); CRC article 24; CERD article 5(e)(iii) |
| Goal 8: Develop a global partnership for development | Charter articles 1(3), 55 and 56; Universal Declaration of Human Rights articles 22 and 28; ICESCR articles 2(1), 11(1) , 15(4), 22 and 23; CRC articles 4, 24(4) and 28(3) |

[a] ICESCR (International Covenant on Economic, Social and Cultural Rights)
ICCPR (International Covenant on Civil and Political Rights)
CERD (International Convention on the Elimination of All Forms of Racial Discrimination)
CEDAW (International Convention on the Elimination of All Forms of Discrimination Against Women)
CRC (Convention on the Rights of the Child)